RAWLINS COUNTY
Dental Clinic

515 State St.   P.O. Box 177   Atwood, KS 67730   785.626.8290   rcdentalclinic.com

Application for Sliding Fee Scale

To qualify for a discount, you must complete this application and attach **3 months proof of income**. If you have no income, a letter verifying this status is required. You must return this application to Rawlins County Dental Clinic (RCDC) within one week to determine your eligibility. If you qualify, your discount will be in effect for **one year from the date of your application**. If your income or household changes, please notify RCDC to be sure you are receiving the proper discount. When your discount expires, you will need to reapply. Please call our office if you have any questions.

Name:_____

Address:_____

Phone:_____

Please list <u>everyone living in your home </u>starting with yourself:

Name:	Age & Birth date	Relationship to you

1._____

2._____

3._____

4._____

5._____

6._____

7._____

8._____

Please continue application on the back.

List **everyone** in the household receiving income (household income includes all income generated by the household, **regardless of marital status)**. Income is, but is not limited to: salaries, pensions, social security, disability, alimony, child support, unemployment, self-employment, tips, VA benefits, etc. ***Three months proof of income is required to process the application.*** **Approval will not be granted without documentation of income. You will be responsible for full fees if proper documentation is not provided within one week from application.**

Name of person working Receiving income.	Type of income	Employer name & phone Number	Monthly amount received **before** taxes/deductions

I understand that any insurance payments received by me or on my behalf must be applied to my account before I receive any discounts. I agree to pay at the time of service. I certify the above information is correct and assume the responsibility of contacting Rawlins County Dental Clinic should any changes occur.

_____

Patient's Signature   Date

FOR OFFICE USE ONLY:

_____

Date application Received: _____

Total Verified income: _____/month/year

Benefit Qualified For: _____

Expiration Date: _____

_____

Signature of Rawlins County Dental Personnel